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ABSTRACT

Although the State Children's Health Insurance Program (SCHIP), in operation for 5 years, has made rapid progress in reducing the number of children in the United States without health insurance coverage, pending reductions in federal funding, the expected reversion of SCHIP funds back to the U.S. Treasury, and growing state budget crises will likely reverse program enrollment and increase the number of uninsured children. This special report describes the SCHIP, discusses the problems contributing to the anticipated drop in SCHIP enrollment, and delineates the anticipated loss of funds for each state and the nation. Case studies are presented to illustrate three strategies used by states to curb spending: (1) freezing enrollment or limiting time periods during which children can enroll; (2) increasing family premium requirements, thereby making program participation less affordable; and (3) undoing eligibility and enrollment simplifications that make it easy for families to enroll and stay enrolled. It is concluded that the loss of approximately $6 billion in federal SCHIP funding is projected to cause 900,000 low-income enrollees to lose health coverage in the near future. Congress is urged to address existing flaws in the federal funding mechanism. (Contains 54 endnotes.) (KB)

Children Losing Health Coverage. Special Report, Revised.

Families USA Foundation
Washington, DC

Rachel Klein

September 19, 2002

FamiliesUSA
The Voice for Health Care Consumers

SPECIAL REPORT

Revised as of September 19, 2002

CHILDREN LOSING HEALTH COVERAGE

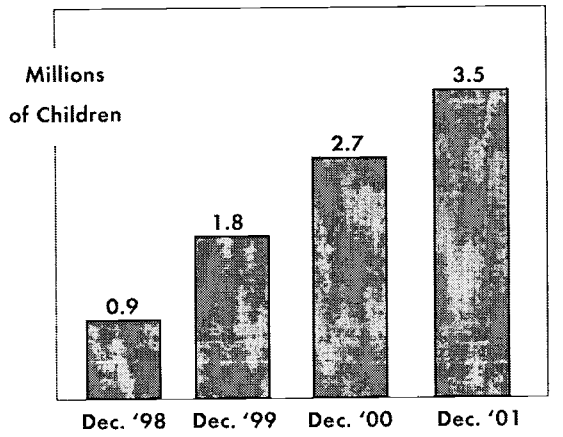
The State Children's Health Insurance Program (SCHIP), now five years old, has made rapid progress in reducing the number of children without health coverage. By December 2001, there were approximately 3.5 million low-income children enrolled in SCHIP.[1] Despite this record of success, and despite the large numbers of children still in need of health insurance coverage, SCHIP's progress may now be reversed. A combination of factors—pending reductions in federal SCHIP funding, the expected reversion of previously allocated federal SCHIP funds back to the U.S. Treasury, and growing state budget crises—is likely to reduce program enrollment and increase the number of uninsured children. The Bush Administration has estimated that SCHIP enrollment will drop by 900,000 between fiscal years 2003 and 2006; the worsening fiscal outlook in the states suggests that this projection may underestimate those losses. This anticipated decline in SCHIP coverage would take place at a particularly inauspicious time, as health care costs and unemployment are rising. Several senators, including Senators Jay Rockefeller and Lincoln Chafee, as well as the original sponsors of SCHIP (Senators Orrin Hatch and Edward Kennedy), have recognized this problem and are working to fix it. Legislation on this matter is likely to be considered before Congress adjourns this fall.

Background

When SCHIP was enacted in 1997, 10 million children in the United States—nearly 14 percent of all children under 19 years of age—were uninsured.[2] Approximately 7 million (70 percent) of those children were in families with incomes below 200 percent of the federal poverty level.[3] Although the vast majority of uninsured children had a parent who worked—75 percent lived with a parent who worked full-time and almost 90 percent lived with a parent who worked full- or part-time[4]—these families either were not offered health insurance by their employers or they could not afford to purchase it.[5]

The enactment of SCHIP gave states $40 billion over 10 years to provide health coverage for low-income, uninsured children who live in families that earn too much to qualify for Medicaid but not enough to afford private insurance. After the passage of SCHIP, most states moved quickly to design and implement expanded health coverage for children. Ultimately, all 50 states, plus the District of Columbia and the U.S. Territories, opted to participate in SCHIP. States undertook outreach efforts to inform low-income families about the program, and most states made it easy for families to enroll their children in SCHIP. As a result, the program experienced steady enrollment increases from year to year.

Figure 1
SCHIP Enrollment in 50 States and the District of Columbia



Source: Kaiser Commission on Medicaid and the Uninsured.

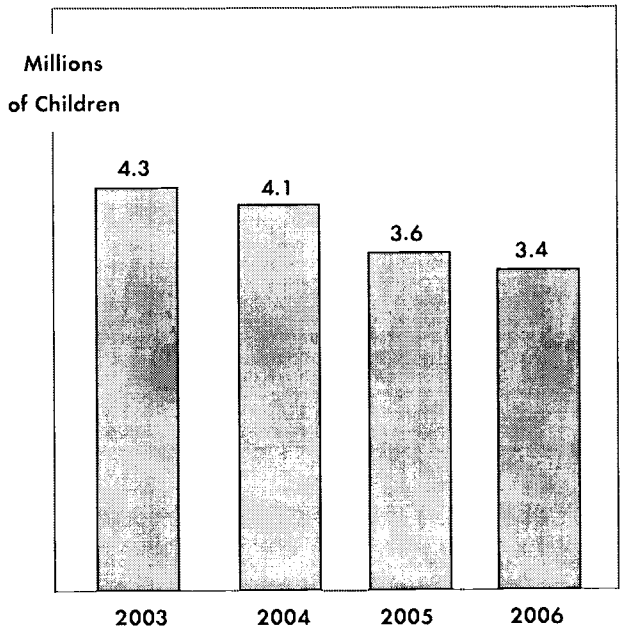
On its fifth anniversary, SCHIP is providing coverage to a significant number of children. Nearly 1 million children gained coverage each year in the program, and, by December 2001, approximately 3.5 million children were enrolled in SCHIP.[6] (See Figure 1.) All indications are that enrollment continued to grow in 2002. The federal government reports that enrollment in the second quarter of fiscal year 2002 was 22 percent higher than enrollment in the same quarter of fiscal year 2001.[7] A new report from the Department of Health and Human Services finds that the percentage of children without health insurance declined from 13.9 percent in 1997 to 10.8 percent in 2001, largely because of enrollment growth in SCHIP.[8]

The new health insurance coverage provided through SCHIP is vital to improving children's access to health care. Uninsured children are six times more likely to lack a usual source of health care than insured children (24 percent vs. 4 percent) and nearly four times as likely to have an unmet health care need (22 percent vs. 6 percent).[9] Long-term uninsured children, on average, receive less than half the number of doctor visits that insured children receive, and they receive only 42 percent of the number of inpatient hospital care days.[10] Conversely, enrollment in health coverage can have a dramatic effect on children's access to health care: One study found that, after being enrolled in a children's health insurance program for a year, the percentage of children reporting an unmet health care need or having delayed health care fell from 57 percent to just 16 percent.[11]

Despite the program's steady growth, there are still nearly 5 million uninsured children who live in families with incomes below the SCHIP eligibility level—set at 200 percent of poverty in most states, or $30,040 in annual income for a family of three.[12] (For a state-by-state listing of uninsured, low-income children, see Table 2 on page 12.) Those low-income, uninsured children constitute 64 percent of all uninsured children in the United States. Hence, the program's continued growth is critically important.

Unfortunately, the ability to sustain steady progress in reducing the number of uninsured children is in jeopardy. Unless action is taken soon, *there is likely to be substantial erosion in SCHIP coverage during the next several years.* In an unheralded projection submitted last February as part of the Bush Administration's proposed fiscal year 2003 budget, *the Office of Management and Budget (OMB) estimated that SCHIP enrollment will decline by 900,000 (approximately one-quarter of the current enrollment) between 2003 and 2006.*[13] (See Figure 2.)

Figure 2
OMB Projects 900,000 Children Will Lose SCHIP Coverage from 2003-2006



Source: Office of Management and Budget.

This projected drop in SCHIP enrollment is the result of three major problems. First, the amount of federal SCHIP funds made available to the states in fiscal years 2002, 2003, and 2004 is considerably lower than the amounts that were made available in the four previous years. Second, almost $3 billion of previously allotted SCHIP funds are scheduled to be taken away from the states and will revert to the U.S. Treasury—$1.2 billion on September 30, 2002 and $1.6 billion on September 30, 2003. Third, the states are experiencing significant budget crises that are causing them to reduce their commitments to low-income health coverage. The depth of those budget crises became clearer after OMB's budget submission last February, and, as a result, its 900,000-projected drop in SCHIP coverage may understate the real loss in such coverage that may be experienced by low-income children.

Causes of Future SCHIP Enrollment Losses

1. The 2002-2004 SCHIP Funding Dip

SCHIP was passed as part of the Balanced Budget Act (BBA) of 1997. Because the primary purpose of the BBA was to improve the federal government's fiscal situation, funding for SCHIP was considered in the context of projections at that time about the bottom-line budget situation for each of the next 10 years. In 1997, it was presumed that the federal budget would be in worse shape in fiscal years 2002-2004 than in the years immediately preceding and immediately following that period. Thus, Congress allocated considerably less money for SCHIP in that three-year period than it did for the four years preceding that period and the three years thereafter.

This so-called "SCHIP funding dip" is substantial. For each of the first four years of SCHIP implementation, starting with fiscal year 1998, the program's block-grant funding provided roughly $4.3 billion to the states. In fiscal years 2002-2004, however, SCHIP funding to the states was reduced by 26 percent—a reduction of $1.125 billion per year.[14] (See Figure 3.) Unfortunately, this funding reduction is occurring at precisely the time when federal funding is most needed—when program enrollment, unemployment, state budget problems, and health care costs are growing. Recent research shows that, for 32 states, the SCHIP allocations for fiscal year 2003 will be lower than the federal share of their projected SCHIP expenditures in that year.[15] (See box.)

32 States Will Receive Lower FY 2003 SCHIP Allocations than the Federal Share of Their 2003 SCHIP Expenditures

Alabama	Louisiana	North Carolina
Alaska	Maine	Ohio
Arizona	Maryland	Pennsylvania
California	Massachusetts	Rhode Island
Colorado	Minnesota	South Carolina
Florida	Mississippi	South Dakota
Idaho	Missouri	Texas
Indiana	Montana	Utah
Iowa	New Jersey	Virginia
Kansas	New York	West Virginia
Kentucky		Wisconsin

Source: Center on Budget and Policy Priorities.

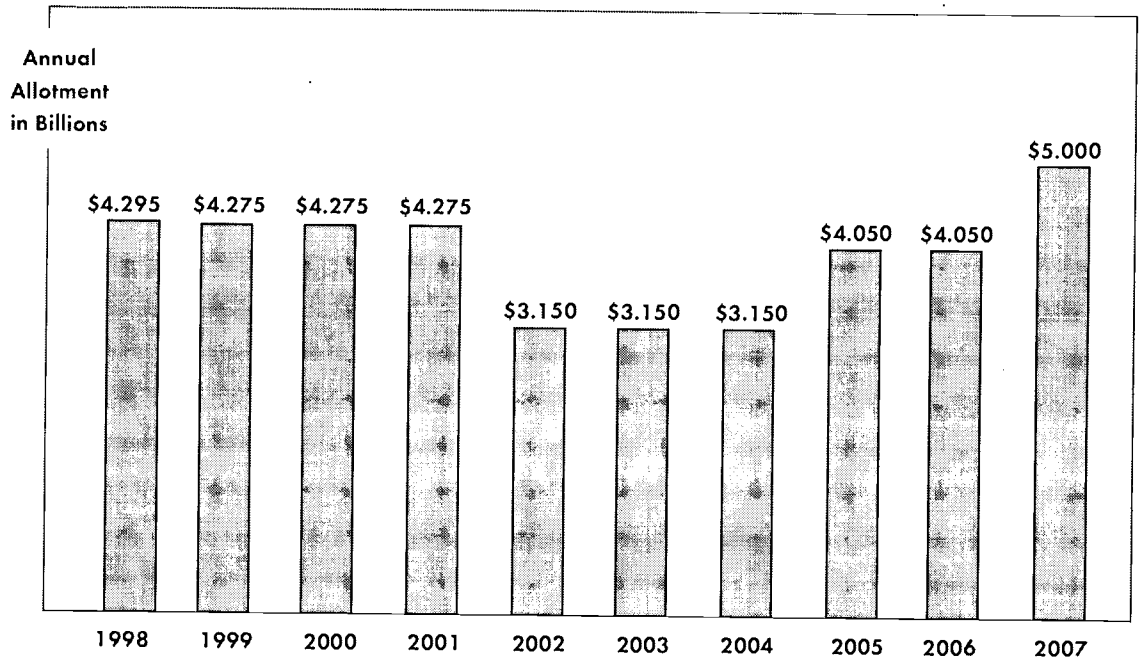
2. Loss of Previously Allocated Federal Funds

At the same time that states are dealing with a reduction in federal support due to the SCHIP funding dip, they are also facing the loss of approximately $2.8 billion in previous federal allocations for the program.[16] These are funds that will revert to the U.S. Treasury because they were not used within the time period established by the SCHIP statute. This loss of program funds is due mainly to the way Congress scheduled the 10-year distribution of SCHIP funds to the states.

As is evident from Figure 3, Congress "front-loaded" SCHIP allocations to the

Figure 3

Federal Funding for SCHIP



Source: Section 2104(a) of the Social Security Act.

states. Specifically, Congress allocated more funding to the states in each of the first four fiscal years of program implementation than it did for any of the succeeding five years; it is only in the 10th year of program operations, in fiscal year 2007, that more money is allocated to the states than the amounts provided in each of the first four years.

This makes little sense because SCHIP, like all new public programs, needed time to get underway. States first had to pass legislation to start the program and then had to develop the program's administrative infrastructure. Only then could they begin the process of informing the public and reaching out to potentially eligible families. Congress provided too much money in the early years of the program but too little in later years. It is little wonder, therefore, that states could not spend their entire first years' allocations.

Under the SCHIP funding formula, states have three years to spend their annual allocations. At the end of the three years, unspent funds are taken from the states and are reallocated to states that did spend all of their funds. Those states have one year to use the reallocated funds before they revert to the Treasury. In December 2000, when it became clear that 40 states would be unable to spend all of their SCHIP funds for fiscal years 1998 and 1999 within the allotted time, Congress enacted a temporary fix. Some funds were reallocated, and states were given a brief extension for the use of funds initially allocated

Table 1

Amount of SCHIP Funds States Will Lose, 2002-2004

State	Unspent Funds Reverting to U.S. Treasury Sept 30, 2002 & 2003	Amount of SCHIP Funds Lost Due to Dip 2002-2004	Total Amount of Lost SCHIP Funds
Alabama	$ 0	$ 60,285,200	$ 60,285,200
Alaska	10,700,000	5,785,587	16,485,587
Arizona	0	108,664,634	108,664,634
Arkansas	44,200,000	51,583,265	95,783,265
California	24,700,000	508,878,466	533,578,466
Colorado	0	29,810,668	29,810,668
Connecticut	0	39,200,178	39,200,178
Delaware	2,100,000	5,624,932	7,724,932
District of Columbia	200,000	11,401,038	11,601,038
Florida	0	161,789,425	161,789,425
Georgia	0	86,113,863	86,113,863
Hawaii	1,500,000	6,247,839	7,747,839
Idaho	37,200,000	11,091,166	48,291,166
Illinois	10,100,000	92,902,788	103,002,788
Indiana	233,400,000	37,149,113	270,549,113
Iowa	0	30,714,374	30,714,374
Kansas	57,300,000	21,221,581	78,521,581
Kentucky	161,000,000	51,015,773	212,015,773
Louisiana	0	70,731,130	70,731,130
Maine	53,000,000	9,962,664	62,962,664
Maryland	130,600,000	51,164,092	181,764,092
Massachusetts	181,500,000	29,918,921	211,418,921
Michigan	0	63,967,806	63,967,806
Minnesota	0	19,833,142	19,833,142
Mississippi	87,800,000	52,736,229	140,536,229
Missouri	162,900,000	56,837,963	219,737,963
Montana	0	12,284,205	12,284,205
Nebraska	0	14,217,405	14,217,405
Nevada	0	10,116,417	10,116,417
New Hampshire	4,400,000	8,170,275	12,570,275
New Jersey	215,500,000	85,328,504	300,828,504
New Mexico	46,500,000	50,512,061	97,012,061
New York	859,400,000	254,987,418	1,114,387,418
North Carolina	100,400,000	64,610,242	165,010,242
North Dakota	0	3,520,700	3,520,700
Ohio	0	98,057,996	98,057,996
Oklahoma	4,600,000	68,741,469	73,341,469
Oregon	0	36,145,981	36,145,981
Pennsylvania	5,600,000	108,139,241	113,739,241
Rhode Island	0	5,191,047	5,191,047
South Carolina	89,600,000	50,020,637	139,620,637
South Dakota	0	6,474,600	6,474,600
Tennessee	7,400,000	70,585,538	77,985,538
Texas	0	440,323,039	440,323,039
Utah	0	20,603,092	20,603,092
Vermont	0	2,469,329	2,469,329
Virginia	0	60,357,365	60,357,365
Washington	75,500,000	53,617,824	129,117,824
West Virginia	0	12,835,892	12,835,892
Wisconsin	114,100,000	29,136,998	143,236,998
Wyoming	900,000	5,483,390	6,383,390
Territories	92,700,000	35,437,500	128,137,500
US Total	$ 2,814,800,000	$ 3,282,000,003	$ 6,096,800,003

Source: Families USA calculations based on allotment information from the US Department of Health and Human Services and estimates of unspent funds reverting to the US Treasury from the Center on Budget and Policy Priorities.

for 1998 and 1999.[17] Since states were also spending funds allocated for the following years, not all of the 1998-1999 funds could be spent. It is these unused 1998-1999 funds, and some unused 2000 funds, that will soon revert to the Treasury unless Congress takes action to extend their availability. At stake is approximately $2.8 billion—funds that are increasingly needed to sustain program growth as well as inflationary health costs borne by SCHIP.

As a result of the SCHIP funding dip—as well as the reversion to the Treasury of earlier allocations— states will have approximately $6 billion less money for SCHIP than they otherwise would have had. (See Table 1.) This loss of federal funding will undoubtedly stunt the program's growth and is a major factor in the projected enrollment losses expected for the period ahead.

3. State Budget Cuts

The loss of federal SCHIP funds comes at a particularly difficult time for states. In 2002, 40 states reported budget shortfalls of $40 billion.[18] Meanwhile, because of increases in enrollment and the cost of providing health care services, SCHIP expenditures are increasing: estimates are that federal expenditures for SCHIP in fiscal year 2003 will be $4.4 billion. This is an 18 percent increase over estimated fiscal year 2002 spending[19] and is almost 40 percent more than states will receive from the federal government in fiscal year 2003.

Since OMB released its estimates of potential enrollment cutbacks, state revenue estimates have declined further, and budget deficits have increased. Although most states have already passed their budgets for 2003, the struggle to meet rising deficits continues as states learn that revenues are lower than anticipated when those budgets were passed. Some states have already taken action to reduce spending or to reduce growth in spending in SCHIP, and others are likely to act in special legislative sessions this year or in their legislative sessions next year. The increasing pressure to reduce health care expenditures comes at exactly the same time that families will need to rely on Medicaid and SCHIP for health coverage as they lose jobs and access to employer-sponsored health insurance and as health costs soar.

The OMB projection of a 900,000 drop in SCHIP enrollment is based primarily on expenditure estimates submitted by states; these state estimates take into account the SCHIP funding dip and the loss of expiring federal SCHIP funds. Because the OMB estimate was prepared in early 2002, it could not take into account the full impact of the economic slowdown on state budgets. The growing financial crises that states are facing could mean that even more than 900,000 enrollees will lose access to SCHIP in the coming years.

How Are States Responding?

The loss of both federal and state funds is forcing states to find ways to curb spending. Some of the strategies states are using to curb spending limit enrollment—either directly or indirectly. Three of the strategies that affect enrollment are: (1) freezing enrollment or limiting time periods during which children can enroll; (2) increasing family premium requirements, thereby making program participation less affordable; and (3) undoing eligibility and enrollment simplifications that make it easy for families to enroll, and stay enrolled, in SCHIP. The following state case studies illustrate these enrollment cutbacks. *In each of the states described below, the projected SCHIP spending will be higher than their allotments in fiscal year 2003.*

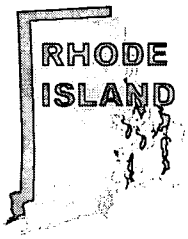
North Carolina's Health Choice program provides coverage for children in families with incomes below 200 percent of poverty. In July 2002, North Carolina announced that it would close enrollment in Health Choice on September 1, 2002[20]—similar to an enrollment freeze implemented by the state almost two years ago. However, on August 28, three days before this second enrollment freeze was scheduled to begin, the state legislature found additional funds that enabled the state to defer the freeze.[21] Although the state has temporarily avoided the second scheduled freeze in the program's short history, it is likely to face this dilemma again. As of July 31, 2002, there were 84,857 children enrolled in the program, and enrollment has been increasing by an average of 4,000 children per month.[22] New estimates indicate that there are 128,100 uninsured children in North Carolina with incomes below the eligibility limit for Health Choice.[23]

An enrollment freeze would reduce SCHIP coverage for low-income children in two ways. First, uninsured children who applied for Health Choice after the freeze took effect would be added to a waiting list until the program reopened to new enrollees. Second, children who temporarily left Health Choice would not be able to re-enroll in the program until the freeze ended. While some children disenroll voluntarily from Health Choice because they can secure coverage through their parents' employers, many others are involuntarily disenrolled because they have difficulty with the renewal process or are unable to pay a premium or annual enrollment fee.[24]

North Carolina has had previous experience with the effects of an enrollment freeze. In December 2000, North Carolina froze enrollment in Health Choice in order to remain within its SCHIP budget.[25] At the time, there were 77,000 children enrolled in the program. During the enrollment freeze, the number of children enrolled in the program dropped precipitously as normal attrition could not be offset by new applicants. By July 2001, only 55,000 children were enrolled in the program—a decline of 22,000 children. Meanwhile, 36,000 children had applied for coverage and been added to the state's waiting list. When the freeze was lifted, half of the children on the

waiting list were enrolled in Health Choice, one-third were eligible for Medicaid and enrolled, and 10 percent had found private insurance. The remaining families did not respond when told that they may be able to enroll in the program.

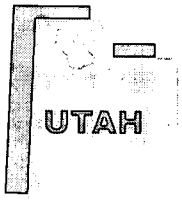
North Carolina has consistently used all of the federal funds allotted to it for children's health coverage. In March 2001, the state received a $92 million reallocation from other states. Because of the limited time given to states to use reallocated funds, North Carolina will be required to return an estimated $87 million of those funds to the U.S. Treasury on September 30, 2002, despite the clear need for additional funds.[26]



Rhode Island provides SCHIP coverage to children in families with incomes up to 250 percent of poverty through its RIteCare program. From its inception, enrollment in the RIteCare expansion grew rapidly—from 2,981 in December 1998 to 12,179 in December 2001.[27] The increase was largely due to a combination of intensive outreach and simplification of the application process that made it easier for families to apply for the program. Rhode Island also expanded health coverage for parents with incomes up to 185 percent of poverty, which research has shown helps to increase children's enrollment because families can enroll together.[28]

It is estimated that there are still approximately 3,900 uninsured children who are eligible for RIteCare.[29] However, the sharp increase in RIteCare enrollment caused concern among state officials about the program's budget. As a result, in January 2002, premiums were established at approximately 3 percent of income for families with incomes over 150 percent of poverty, and, starting in April 2002, families were cut off of the program for non-payment of the premium. In that first month, 1,197 people were terminated from RIteCare for failure to pay the premium; 882 (or 74 percent) of those terminated were children.[30] By the end of June 2002, 1,961 people—almost three-quarters of them children—were terminated from the program due to non-payment of the premium.

The Rhode Island legislature, concerned about the fiscal needs of the program, authorized even higher premiums to be established in RIteCare effective July 1.[31] Premiums rose to 4 percent of family income: $61 per month for families with incomes between 150 and 185 percent of poverty; $74 per month for families with incomes between 186 and 200 percent of poverty; and $92 per month for families with incomes between 201 and 250 percent of poverty. These premium costs are unaffordable for many low-income families and will undoubtedly result in a further drop-off in RIteCare participation. Rhode Island has consistently used all of the federal funds available to it under SCHIP. Estimates of future spending indicate that it will be the first state to run out of federal SCHIP funds because of the SCHIP funding dip.[32]

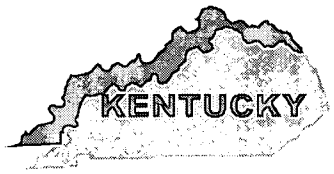


Utah CHIP provides coverage for uninsured children with family incomes at or below 200 percent of the federal poverty level. Enrollment began in August 1998 and grew steadily from 4,390 in December 1998 to 26,427 in December 2001.[33] During the first few years of the program, Utah made several policy changes that enhanced the benefit package and made it easier for families to stay enrolled. For example, in 2001, the dental benefit was enhanced, and the renewal process was changed to reduce the amount of paperwork a family was required to submit to the agency each year.[34]

Utah has recently made three changes in CHIP to keep the program's expenditures within its budget. On December 10, 2001, Utah instituted a freeze in enrollment.[35] In February 2002, the state initiated a monthly premium for families with incomes over 100 percent of poverty. In addition, the state reduced the dental benefit available to children so that it now only provides basic preventive and emergency care.[36]

Since December 2001, enrollment has remained closed to new applicants except for a two-week period from June 3 through June 14, 2002. Between December and June, enrollment in CHIP fell by 7,000 children—26 percent of the total caseload.[37] Utah has not established a waiting list for applicants, so there is no information about the number of uninsured children who are waiting to enroll in the program. However, the state received applications from approximately 13,000 children during the open enrollment period.[38] The strong response to the open enrollment period indicates that there is significant unmet need for CHIP in Utah, and recent estimates indicate that there are still 39,500 uninsured low-income children in Utah who could benefit from the health coverage provided by CHIP or Medicaid.[39] The state does not currently plan to lift the freeze, and no further open enrollment periods are currently scheduled.

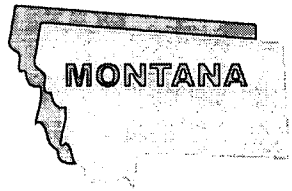
Shortly after the enrollment freeze began, Utah began to charge families a monthly premium to participate in CHIP. Research indicates that premiums have a significant impact on enrollment in public health insurance programs, and it is likely that some of the attrition in the program was due to the new premiums.[40] Initially, the premiums were $5 per month per child for families with incomes between 101 and 150 percent of poverty, and $10 per month per child for families with incomes between 151 and 200 percent of poverty. On July 1, 2002, the premium schedule was changed from monthly to quarterly, and the amounts were lowered to $13 per family per quarter for families with incomes between 101 and 150 percent of poverty and $25 per family per quarter for families with incomes between 151 and 200 percent of poverty.[41]



Kentucky phased in its KCHIP program, beginning with a Medicaid expansion to adolescents in families with incomes up to 100 percent of poverty in July 1998.[42] In July 1999, the state expanded Medicaid to 150 percent of poverty for all children under age 19, and then, in November 1999, Kentucky established KCHIP for children with family incomes up to 200 percent of poverty. Through a combination of extensive outreach efforts and a simple enrollment process, enrollment in Medicaid and KCHIP grew quickly, from 5,188 in December 1998 to 28,068 in December 1999, and then nearly doubling to 52,653 by December 2000.[43] It is estimated that there are still 41,000 uninsured, low-income children in Kentucky who are eligible for Medicaid or KCHIP.[44]

However, on July 1, 2002, Kentucky eliminated the mail-in application form for Medicaid and KCHIP. The state now requires families to apply in person at the local welfare office, making Kentucky one of only three states in the nation to require families to apply for children's health insurance coverage at a welfare office.[45] The vast majority of children eligible for Medicaid and KCHIP live in families with working parents; for their parents, it is difficult to arrange in-person interviews at a welfare office during the workday. In Kentucky, local welfare offices are not required to provide evening or weekend appointments.[46]

Based on SCHIP experiences around the country, Kentucky's more cumbersome application processes will probably lead to declines in enrollment.[47] In fact, Kentucky has already had experience showing that adding complexity to the enrollment process results in drops of KCHIP participation. In August 2001, Kentucky eliminated the mail-in form that families had used to renew their children's eligibility for KCHIP, requiring families to go to a local welfare office to renew their enrollment.[48] At the same time, it reinstituted a requirement that families provide documentation of their income by submitting paycheck stubs with their renewal materials. Kentucky experienced a drop in KCHIP enrollment of 2,167 children from December 2000 to December 2001.[49]



Montana received approval for the Montana Children's Health Insurance Program (CHIP) in September 1998.[50] The program established a separate state health insurance program for children under 19 in families with incomes up to 150 of poverty. Enrollment began in January 1999, and, by December 1999, 2,458 children were enrolled.[51]

During the following year, the state made improvements in CHIP and related programs to strengthen program services and to make it easier for families to secure health coverage. The state implemented a joint application for CHIP, Medicaid, and other programs serving children; eliminated the annual enrollment fee; added benefits for dental services and eyeglasses; and eliminated copayment requirements

for Native Americans and Alaskan natives. Largely as a result, by December 2000, enrollment in CHIP increased to 9,700 low-income children.[52]

In January 2001, Montana reached its state-established cap on CHIP enrollment.[53] Beginning on that date, children who applied for the program were placed on a waiting list; they could only be enrolled in the program once slots became available due to program attrition. The waiting list has an average of 500-600 children each month, and children stay on the waiting list (and remain uninsured) an average of two to three months. It is estimated, however, that there are still approximately 24,900 uninsured, low-income children in the state who are eligible for CHIP or Medicaid but not enrolled.[54]

Conclusion

The loss of approximately $6 billion in federal SCHIP funding—occurring at the same time that states are experiencing severe fiscal shortfalls—is projected to cause 900,000 (and possibly considerably more) low-income program enrollees to lose health coverage in the near future. Congress now has an opportunity to address at least part of this problem by fixing the flaws in the federal funding mechanism. Unless Congress acts before it adjourns, states are likely to cut back spending on children's health care coverage, adding more and more children to the ranks of the uninsured.

Table 2

Remaining Uninsured Low-Income Children in the 50 States and the District of Columbia

State	Uninsured Low-Income Children	State	Uninsured Low-Income Children	State	Uninsured Low-Income Children
United States	**4,745,600**	Kentucky	41,000	North Dakota	7,800
Alabama	78,400	Louisiana	132,900	Ohio	177,600
Alaska	18,300	Maine	8,600	Oklahoma	77,500
Arizona	116,300	Maryland	32,500	Oregon	77,200
Arkansas	60,200	Massachusetts	44,500	Pennsylvania	64,400
California	988,600	Michigan	161,500	Rhode Island	3,900
Colorado	74,400	Minnesota	84,300	South Carolina	48,600
Connecticut	22,800	Mississippi	42,000	South Dakota	10,100
Delaware	7,800	Missouri	59,000	Tennessee	19,300
District of Columbia	4,700	Montana	24,900	Texas	564,400
Florida	394,300	Nebraska	31,300	Utah	39,500
Georgia	76,700	Nevada	55,000	Vermont	8,700
Hawaii	11,100	New Hampshire	15,000	Virginia	122,000
Idaho	29,600	New Jersey	84,300	Washington	64,300
Illinois	144,300	New Mexico	87,100	West Virginia	24,400
Indiana	80,400	New York	177,800	Wisconsin	34,600
Iowa	28,800	North Carolina	128,100	Wyoming	7,100
Kansas	47,300				

Source: Urban Institute for Covering Kids.

Endnotes

[1] Vernon K. Smith and David Rousseau, *SCHIP Program Enrollment: December 2001 Update* (Washington: Kaiser Commission on Medicaid and the Uninsured, June 2002).

[2] National Center for Health Statistics, "Table 1.1 Number and Percent of persons without health insurance coverage, by age group: United States, 1997-2001," Early Release of Selected Estimates Based on Data From the 2001 NHIS, July 15, 2002. Available online at (www.cdc.gov/nchs/about/major/nhis/released200207.htm).

[3] Kaiser Commission on the Future of Medicaid, "State Children's Health Insurance Program," *Legislative Summary* (Washington: Kaiser Commission on the Future of Medicaid, September 1997).

[4] Office of Health Policy, Assistant Secretary for Planning and Evaluation, "Tabulations of the March 1997 Current Population Survey" (Washington: Department of Health and Human Services, December 1997).

[5] James D. Reschovsky and Peter J. Cunningham, "CHIPing Away at the Problem of Uninsured Children," *Issue Brief 14* (Washington: Center for Studying Health System Change, August 1998).

[6] Vernon K. Smith and David Rousseau, op. cit.

[7] Centers for Medicare and Medicaid Services, *The State Children's Health Insurance Program Quarterly Enrollment Report, Second Quarter Fiscal Year 2002: January 1, 2002-March 31, 2002* (Baltimore: Centers for Medicare and Medicaid Services, July 19, 2002). Available online at (http://www.cms.gov/schip/fy02sqer.pdf).

[8] National Center for Health Statistics, op. cit.

[9] Paul Newacheck, et al., "Health Insurance and Access to Primary Care for Children," *New England Journal of Medicine* 338, No. 8, pp. 513-19, as cited in Kaiser Commission on Medicaid and the Uninsured, "Children's Health—Why Health Insurance Matters," *Key Facts* (Washington: Kaiser Commission on Medicaid and the Uninsured, May 2002).

[10] Families USA, *Unmet Needs: The Large Differences in Health Care Between Uninsured and Insured Children* (Washington: Families USA, June 1997).

[11] Judith R. Lave, Christopher R. Keane, Chyongchiou J. Lin, Edmund M. Ricci, Gabriele Amersbach, and Charles P. LaVallee, "Impact of a Children's Health Insurance Program on Newly Enrolled Children," *Journal of the American Medical Association* 279, No. 22 (June 10, 1998): 1820-1825.

[12] The Urban Institute, *Uninsured Children (Ages 0-18) and SCHIP/Medicaid Enrollment Estimates* (Washington: Covering Kids, July 2002). Available online at (www.coveringkids.org/entrypoints/press/UrbanMethodology.pdf).

[13] Office of Management and Budget, *Analytical Perspectives, Budget of the United States Government, Fiscal Year 2003* (Washington: Office of Management and Budget, February 2002), p. 297.

[14] P.L. 105-33, Title IV-J.

[15] Edwin Park, Leighton Ku, and Matthew Broaddus, *OMB Estimates Indicate that 900,000 Children Will Lose Health Insurance Due to Reductions in Federal SCHIP Funding: Congress Could Extend the Availability of Expiring SCHIP Funds and Undo the Reduction in SCHIP Funding Levels to Avert a Large Enrollment Decline* (Washington: Center on Budget and Policy Priorities, July 15, 2002).

[16] Ibid.

[17] The Medicare, Medicaid, and SCHIP Benefit Improvement and Protection Act of 2002 (BIPA) adopted as part of the Consolidated Appropriations Act 2001(P.L. 106-554), gave states until September 30, 2002 to spend FY 1998 and FY 1999 federal SCHIP funds. BIPA established a formula that resulted in the reallocation of approximately 40 percent of the unspent funds to the states that spent their entire FY 1998 and 1999 allocations within the three-year period established by the SCHIP statute. The other states were allowed to keep approximately 60 percent of their unspent funds.

[18] National Association of State Budget Officers and National Governor's Association, *The Fiscal Survey of States: May 2002* (Washington: National Association of State Budget Officers and National Governor's Association, May 2002).

[19] National Association of State Budget Officers and National Governor's Association, *Medicaid and Other State Health Care Issues: The Current Situation* (Washington: National Association of State Budget Officers and National Governor's Association, May 2002).

[20] Brent Lancaster, "Insurance Program Is for Children," *Burlington Times-News*, July 22, 2002.

[21] Associated Press, "Hold on health plan is averted: Program can continue to take poor children," *Winston-Salem Journal*. August 30, 2002.

[22] June Milby, Division of Medical Assistance. North Carolina Department of Health and Human Services. telephone interview by author, July 31, 2002.

[23] The Urban Institute, op. cit.

[24] North Carolina charges families an annual enrollment fee of $50 per family. The state reports that failure to pay the enrollment fee is the leading cause of SCHIP denials. See North Carolina Division of Medical Assistance, *State SCHIP Annual Report: Federal Fiscal Year 2001* (Raleigh, NC: Division of Medical Assistance, September 2001). Available online at (www.cms.gov/schip/charnc01.pdf).

[25] North Carolina Division of Medical Assistance, op. cit.

[26] Milby, telephone interview.

[27] Vernon K. Smith and David Rousseau, op. cit.

[28] Jeanne Lambrew, *Health Insurance: A Family Affair* (New York: The Commonwealth Fund, May 2001); Leighton Ku and Matthew Broaddus, *The Importance of Family-Based Insurance Expansions: New Research Findings about State Health Reforms* (Washington: Center on Budget and Policy Priorities, September 2000).

[29] The Urban Institute, op. cit.

[30] Linda Katz, Poverty Institute, Rhode Island College, telephone interview by author, July 25, 2002.

[31] Conversation with Tricia Leddy, Center for Child and Family Health, Rhode Island Department of Human Services, Philadelphia, PA, August 5, 2002.

[32] Edwin Park, Leighton Ku, and Matthew Broaddus, op. cit.

[33] Vernon K. Smith and David Rousseau, op. cit.

[34] Utah Department of Health, *State SCHIP Annual Report: Federal Fiscal Year 2001* (Salt Lake City, UT: Department of Health, January 2, 2002). Available online at (www.cms.gov/schip/charut01.pdf). Accessed July 31, 2002.

[35] Ibid.

[36] Amy Bingham, Utah Department of Health, telephone interview by author, August 2, 2002

[37] Judi Hilman, Health Care Analyst, Utah Issues, telephone interview by author, July 19, 2002.

[38] Bingham, telephone interview.

[39] The Urban Institute, op. cit.

[40] Families USA, "Increased Premiums and Cost Sharing," *Preserving Medicaid in Tough Times: An Action Kit for Advocates* (Washington: Families USA, 2002). Available online at (www.familiesusa.org/Action%20Kit%20State%20Advocates/6_Cost%20sharing.pdf).

[41] Bingham, telephone interview. The state realized that they could charge families less if they only collected the premiums on a quarterly basis because collecting premiums less frequently reduced the administrative cost of collecting them.

[42] Kentucky Cabinet for Health Services, *Welcome to the Kentucky Children's Health Insurance Program.* Available online at (www.chs.state.ky.us/kchip). Accessed August 14, 2002.

[43] Vernon K. Smith and David Rousseau, op. cit.

[44] The Urban Institute, op. cit.

[45] Donna Cohen Ross and Laura Cox, *Enrolling Children and Families in Health Coverage: The Promise of Doing More* (Washington: Kaiser Commission on Medicaid and the Uninsured, June 2002).

[46] Conversation with Elizabeth Farley, Branch Manager, Children's Health Insurance Program, Kentucky Department for Medicaid Services, Philadelphia, PA, August 6, 2002.

[47] Cindy Mann, David Rousseau, Rachel Garfield, and Molly O'Malley, *Reaching Uninsured Children through Medicaid: If You Build It Right, They Will Come* (Washington: Kaiser Commission on the Future of Medicaid and the Uninsured, June 2002).

[48] Cabinet for Health Services, "Health Services Announces Enrollment Changes for Medicaid and KCHIP" Press Release, (Frankfort, KY: Cabinet for Health Services, April 26, 2001).

[49] Vernon K. Smith and David Rousseau, op. cit.

[50] Centers for Medicare and Medicaid Services, *Montana Title XXI State Plan Summary* (Baltimore: Centers for Medicare and Medicaid Services, updated on May 16, 2002). Available online at (httpL//www.cms.gov/schip/chpfsmt.asp). Accessed July 30, 2002.

[51] Vernon K. Smith and David Rousseau, op. cit.

[52] Centers for Medicare and Medicaid Services, *Montana Title XXI State Plan Summary*, op. cit.

[53] Mary Noel, Bureau Chief, Health Care Resources Bureau, Montana Department of Public Health and Human Services, telephone interview by author, August 12, 2002.

[54] The Urban Institute, op. cit.

SPECIAL REPORT

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